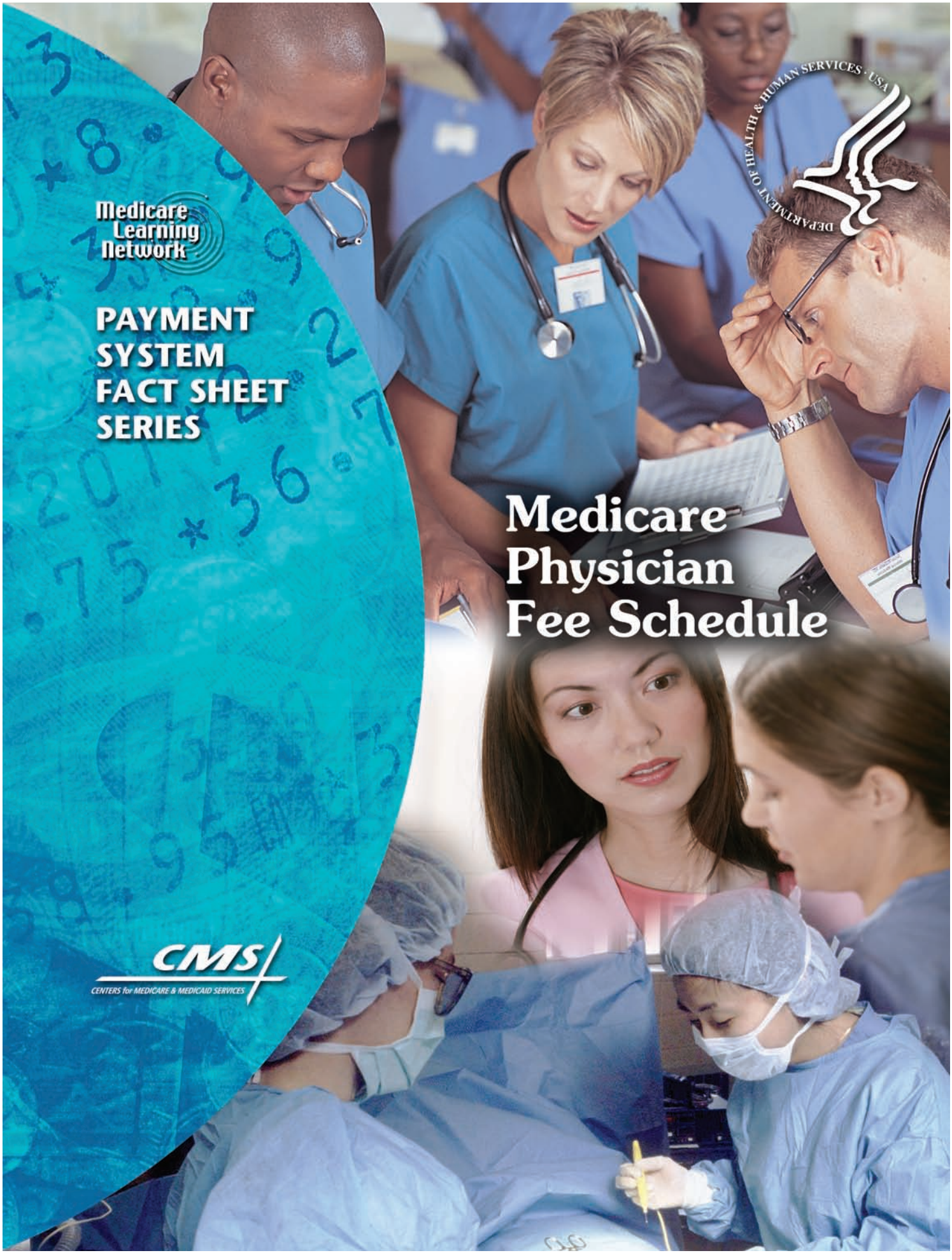

Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Medicare Physician Fee Schedule
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Part B pays for physician services based on the Medicare Physician Fee Schedule (MPFS), which lists the more than 7,000 covered services and their payment rates. Physician services include the following:

- Office visits;
- Surgical procedures; and
- A broad range of other diagnostic and therapeutic services.

Physician services are furnished in all settings including:

- Physicians' offices;
- Hospitals;
- Ambulatory Surgical Centers;
- Skilled Nursing Facilities and other post-acute care settings;
- Hospices;
- Outpatient dialysis facilities;
- Clinical laboratories; and
- Beneficiaries' homes.

MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES

Payment rates for an individual service are based on three components:

1) Relative Value Units (RVU)

The three separate RVUs that are associated with the calculation of a payment under the MPFS are:

- Work RVUs reflect the relative levels of time and intensity associated with furnishing a physician fee schedule service and account for more than 50 percent of the total payment associated with a service. By statute, all work RVUs must be examined no less often than every five years. The calendar year (CY) 2007 Physician Fee Schedule Final Rule, which appeared in the ***Federal Register*** on December 1, 2006, included the impact of the Five Year Review of physician work RVUs. The estimated $4.0 billion impact of changes in the work RVUs resulted in application of a separate 10.1 percent adjustment to all work RVUs.
- Practice expense (PE) RVUs are the costs related to maintaining a practice such as renting office space, buying supplies and equipment, and staff costs. PE RVUs account for approximately 45 percent of the total payment associated with a given service. The CY 2007 Physician Fee Schedule Final Rule also implements the revised PE methodology, which is a "bottom-up approach" that combines the costs of the direct inputs associated with a service. The direct inputs associated with a service are based primarily on recommendations from the American Medical Association's Relative Value Update Committee for the clinical staff, supplies, and equipment required for the service. These costs are converted into direct cost PE RVUs to cover the

clinical staff, equipment, and supplies associated with the service. The CY 2007 Physician Fee Schedule Final Rule adopts the new methodology for determining PE RVUs (such as office overhead), as proposed, but phases in the changes over a four year period. This methodology will be more transparent than the previous PE methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of PE payments.

- Professional Liability Insurance (PLI) RVUs represent the remaining portion of the total payment associated with a service. There were no revisions to the PLI RVUs in the CY 2007 Physician Fee Schedule Final Rule.

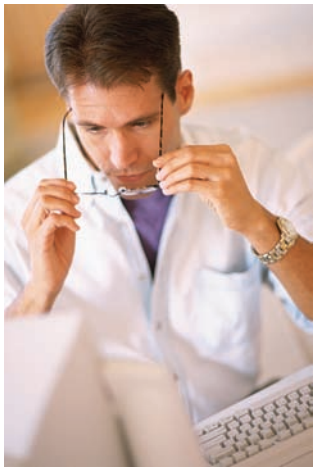
2) Conversion Factor (CF)

To determine the payment rate for a particular service, the sums of the three separate RVUs are multiplied by a dollar CF. The CF is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation. Based on the criteria discussed above, the update to the CF for CY 2007, as published in the December 1, 2006 Physician Fee Schedule Final Rule resulted in a CF of $35.9848. However, as a result of the Tax Relief and Health Care Act of 2006, **the new CF for 2007 is $37.8975** (which is the same as the 2006 CF).

We note that this legislation does ***not*** maintain the payment rates for individual physicians' services at 2006 levels. There are a number of other factors that will affect these payment rates in 2007. These include the Five Year Review of physician work RVUs and the statutorily required budget neutrality adjustment, changes in the PE RVU-setting methodology, refinements to the PE RVUs, reweighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act of 2005, and other annual refinements including coding changes.

3) Geographic Practice Cost Indices (GPCI)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated a 1.0 floor for work GPCIs, which was scheduled to expire effective January 1, 2007. The Tax Relief and Health Care Act of 2006 extended the application of the 1.0 floor in the work GPCI for any locality for which the index is less than 1.0 until December 31, 2007.



MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES FORMULA

[(Work RVU x Budget neutrality adjustor (0.8994)* x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF

* Round the product of the two factors (i.e., the Work RVU and Budget neutrality adjustor) to two decimal places.

To find additional information about the MPFS, visit **www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp** on the CMS website.

Medicare Contracting Reform (MCR) Update
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform/** on the CMS website.

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